

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5667

CERTIFICATE OF DEATH

Reg. Dist. No.

06786

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS R.D. # 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle H.	Last Allen	4. DATE OF DEATH May 30, 1960	Month May	Day 30	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 30, 1872	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Allen		14. MOTHER'S MAIDEN NAME Susan Cremer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Walter Henderson, Elkton, Md.		Address R.D. # 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) (c) DUE TO Anterior clavicle						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15/60 to 5/30/60, that I last saw the deceased alive on 5/30/60, and that death occurred at 1:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE George J. Kline, M.D.						ADDRESS (Street, city or town, state) 6103/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1960		22c. NAME OF CEMETERY OR CEMATORIAL John Brown Cemetery		22d. LOCATION (City, town, or county) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Kline, Elkton, Md.		ADDRESS Ralph E. Kline, Elkton, Md.		REG. REC'D. BY REGISTRAR JUN 10 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DECAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5665		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Cecil		MARYLAND		a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Chesapeake City		Lifetime		X Chesapeake City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Morgan Nursing Home		1 Bethel Rd.				
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year	
Harry Clement Borger				May 10	1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
M		W		Dec. 19, 1871		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Boat Master		Canal boats		Md.		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Michael Borger		Katherine Schreiber				Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
NO		221-20-8510		Henry Borger		Chesapeake City
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Renal failure				3 mos.
446X						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.						
DUE TO						
(b)		Nephrosclerosis, severe				Years
DUE TO						
(c)		Atherosclerosis, generalized, severe				Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19						
21. I certify that I attended the deceased from		May 4, 1960, to May 10, 1960				that I last saw the deceased alive on
ACTUAL SIGNATURE		123 J. J. G. Ave.				ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type)		Elton Md.				DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)
BURIAL		MAY 13, 1960		BETHEL CEMETERY		MR. CHESAPEAKE CITY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME		Elton Md.		DATE MAY 16 '60		Elton Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle town R.D.2		c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown R.D.2			
3. NAME OF DECEASED (Type or print) Lena		First Elizabeth	Middle Collins		
4. DATE OF DEATH Month 5	Day 26	Year 1960	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 11-28-1887		
WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 72 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Caleb S. Cannon		14. MOTHER'S MAIDEN NAME Anna R. Degan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-26-5614			
17. INFORMANT		Address Gilbert Collins, Middletown R.D.2. Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH -					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson		DATE SIGNED 5-26-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF May 26 1960	22c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows	22d. LOCATION (City, town, or county) (State) Baltimore Del.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS ELKTON, MD	24a. REC'D BY REGISTRAR DATE JUN 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

WILSON COUNTY, TENNESSEE
WILSON COUNTY, TENNESSEE

202

Wilson

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5668

CERTIFICATE OF DEATH

Reg. Dist. No.

05645

1. PLACE OF DEATH a. COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 16 7 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Principio		b. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 142 W. Main St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Al	Middle Len	4. DATE OF DEATH	Month 5	Day 1	Year 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years (last birthday) yrs.)	
Male		White		Nov. 15, 1878		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Depot, U.S. Veterans Administration		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eden W. Creswell				14. MOTHER'S MAIDEN NAME Margaret Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
No		None		Mrs. Mary Henry		Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 0 Weeks							
420-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)					
DUE TO							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)
19							
21. I certify that I attended the deceased from <u>March 4, 1960</u> to <u>May 1, 1960</u> , that I last saw the deceased alive on <u>May 1, 1960</u> , and that death occurred at <u>3:15 p.m.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 233 E. Main St.							
ACTUAL SIGNATURE S. RALPH ANDREWS, JR., M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 4, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Asbury Methodist Cen.		22d. LOCATION (City, town, or county) Port Deposit (Rural) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant							
ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE MAY 4 '60		24b. REGISTRAR'S SIGNATURE Cathleen S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5681

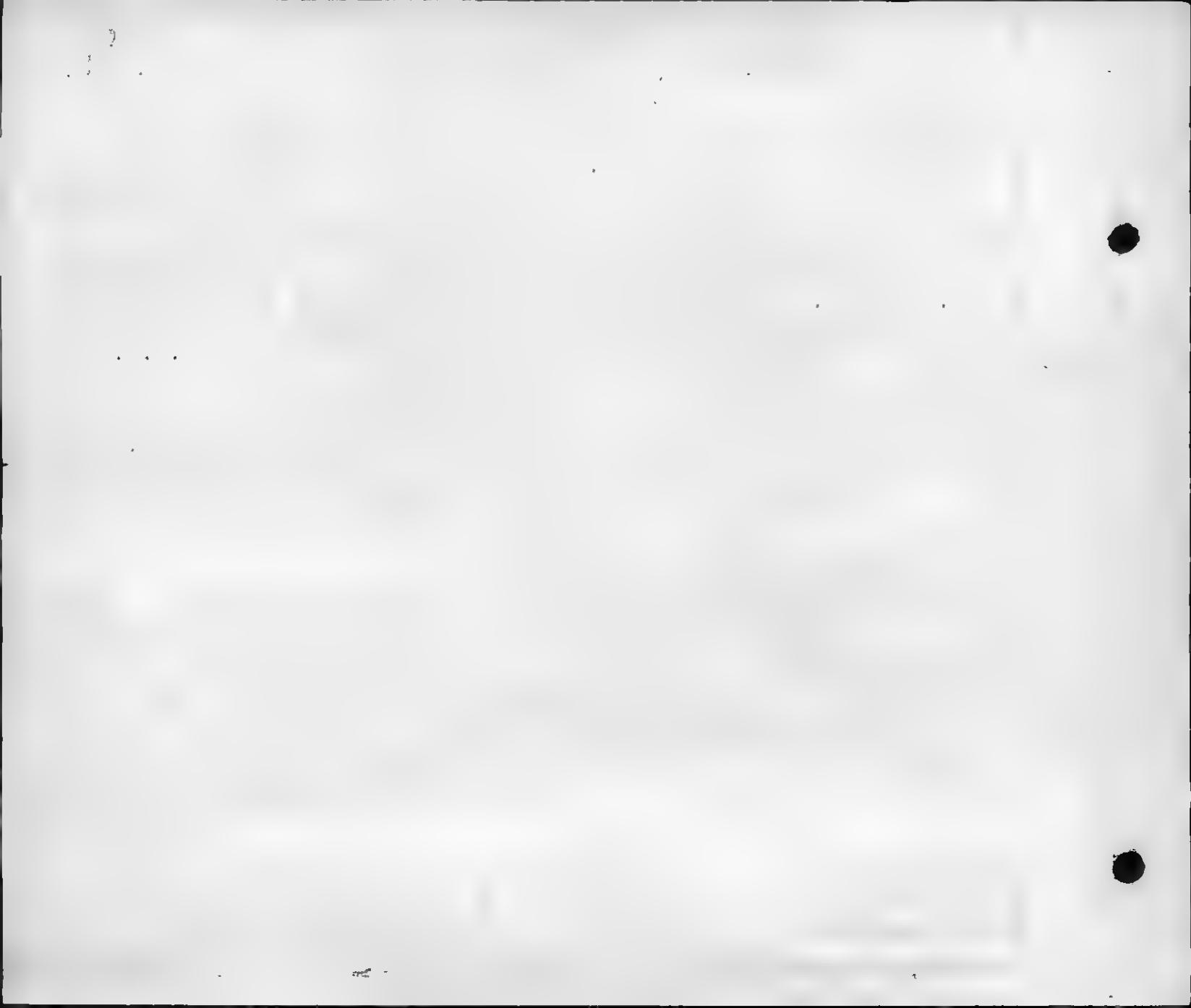
CERTIFICATE OF DEATH

05646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY CECIL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. LENGTH OF STAY IN 1b 17 Yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		X RISING SUN				
3. NAME OF DECEASED (Type or print) ELSIE		First MAE	Middle (Dollinger)			
4. DATE OF DEATH 5/ 19/ 1960	Month	Day	Year			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1895	9. AGE (In years less birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME WILLIAM CAPPELLER		14. MOTHER'S MAIDEN NAME ANNA SIBLE		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NOONE		17. INFORMANT ADOLPH DOLLENGER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.1 DUE TO <i>Adeno-carcinomatosis</i> INTERVAL BETWEEN ONSET AND DEATH 2 years Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>original carcinoma of transverse colon</i> 2 years (c)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/19/1959 to 5/19/1960 that I last saw the deceased alive on 5/19/1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Neil Taylor</i> M.D. ADDRESS (Street, city or town, state) <i>Rising Sun, Md</i> DATE SIGNED <i>5/20/60</i> NAME (Type) <i>Neil Taylor</i> <i>Rising Sun, Md</i> <i>5/20/60</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21/60		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore		22d. LOCATION (City, town, or county) Baltimore (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Heilman Hirsch Sons. Crematorium</i>		ADDRESS <i>2624</i>		24a. REC'D BY REGISTRAR DATE MAY 23 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05647

5682

1. PLACE OF DEATH

COUNTY

Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL and give nearest town)

Perry Point

NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Veterans Administration Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Perryville,

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

May

21

19 60

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years last birthday)

34

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months Days Hours Min

Male

White

WIDOWED

DIVORCED

8-17-25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Explosive Operator

Federal

Perryville, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Gove S. Donovan

14. MOTHER'S MAIDEN NAME

Grace

Minker

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of serv.)

Yes. WW1

16. SOCIAL SECURITY NO.

17. INFORMANT

220-12-5624 Ruth Donovan, wife, Perryville, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Broncho pneumonia

INTERVAL BETWEEN ONSET AND DEATH

5 days

178X
 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the under-
 lying cause last.

DUE TO

DUE TO

DUE TO

(b) pulmonary metastases, from embryonal cell

over 6mos.

(c) carcinoma, left testicle

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
 Hour a. m. 19
 p. m.

20d. INJURY OCCURRED
 While Not while
 at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1960, to May 21, 1960, ~~and that death occurred at 1:30 AM from the causes and on the date stated above.~~

22a. SIGNATURE

Joseph H. Hooper, Jr. M.D.

M.D.

ATTENDING PHYS

MED DIRECTOR

STAFF PHYS

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

JOSEPH H. HOOPER, Jr. M.D., Resident in Surgery, V.A. Hospital, Perry Point, Md.

22d. ADDRESS

23a. BURIAL CREMATION

Burial (Specify)

23b. DATE THEREOF

5-24-1960

23c. NAME OF CEMETERY OR CREMATORI

Hopewell Cemetery

23d. LOCAT ON (City, town, or county)

(State)

Port Deposit, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

See a. Patterson & Son Perryville Md.

25a. REC'D BY REGISTRAR

DATE MAY 24 '60

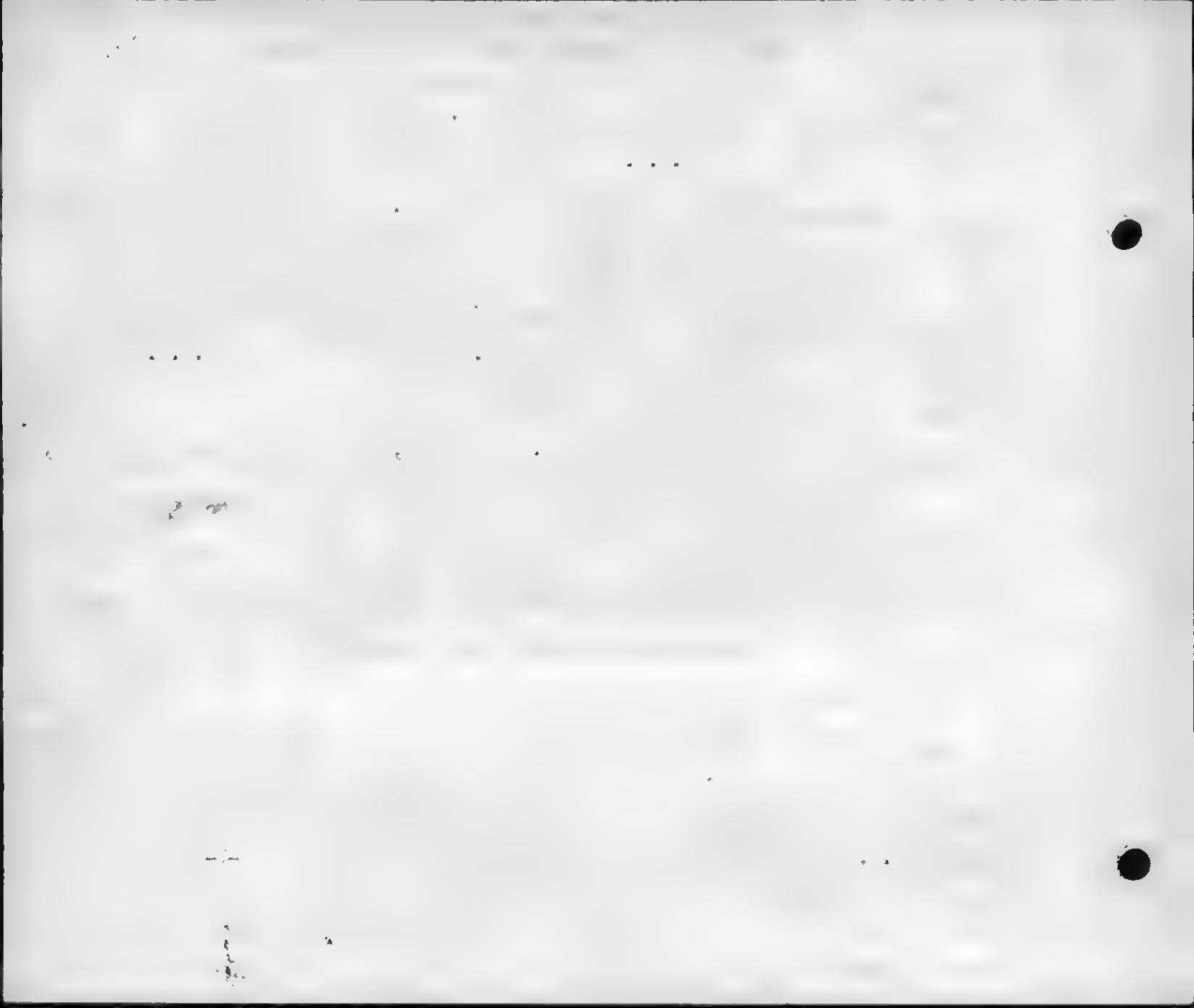
25b. REGISTRAR'S SIGNATURE

Charles S. Tamm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05648**

1. PLACE OF DEATH a. COUNTRY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
MARYLAND		a. STATE Md.	b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb D. A. A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marie	Middle Dunn	4. DATE OF DEATH 5 7 1960		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1914		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Res?			
10c. FATHER'S NAME William Arterbridge		11. BIRTHPLACE (State or foreign country) Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME Lucy Ingram			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 221-18-3678			
17. INFORMANT Mrs. Miles Hart		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL EXAMINER R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-7-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 5/10/60	22c. NAME OF CEMETERY OR CREMATORIALY Gracelawn Memorial Park, Farnhurst, Delaware	22d. LOCATION (City, town, or county) (State) Gracelawn Memorial Park, Farnhurst, Delaware		
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald W. De	ADDRESS ELYTON, Md.	24a. REC'D BY REGISTRAR DATE MAY 12 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial or transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Penns. Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville King of Prussia		d. STREET ADDRESS 553 Crossfield Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT		First S.	Middle FREED
4. DATE OF DEATH May 23 1960	Month May	Day 23	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Private Practice	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Freed		14. MOTHER'S MAIDEN NAME Marie Backes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Kathleen Freed, wife, 553 Crossfield Road		King of Prussia, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Hemorrhage, massive, gastro-intestinal tract INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
Varix of the esophagus		unknown	
Laennec's cirrhosis		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that J. L. Garey (this hospital) attended the deceased from May 13 1960 to May 23 1960 , xxxxxx , and that death occurred at 4:45 p.m. from the causes and on the date stated above			
22a. SIGNATURE J. L. Garey		22b. DATE SIGNED 5-24-60	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - 5/26/60		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	
23d. LOCATION (City, town, or county) (State) Arlington, Virginia		25a. REC'D BY REGISTRAR DATE MAY 31 '60	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		25b. REGISTRAR'S SIGNATURE Arthur S. Hause	
ADDRESS Havre de Grace, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5684

CERTIFICATE OF DEATH

Reg. Dist. No.

05650

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Earleville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Earleville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) William		First H.	Middle Hall			
4. DATE OF DEATH May 3 1960	Month May	Day 3	Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1869			
9. AGE (In years lost birthday) 90	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer-Fisherman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME William S. Hall		14. MOTHER'S MAIDEN NAME Alice Louns				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Ozella L. Hall, Address Earleville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal disease INTERVAL BETWEEN ONSET AND DEATH 15 years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) General Arteria sclerosis +10 years DUE TO (c)						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 700 injury	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from 9/24/59 to 5/3/60 , 19, that I last saw the deceased alive on 5/3/60 , 19, and that death occurred at 2:57 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE H. H. Hamilton ADDRESS (Street, city or town, state) M.D. Wellington, Md. DATE SIGNED 5/3/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Galena Cemetery	22d. LOCATION (City, town, or county) Galena Kent Co. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		ADDRESS Wellington, Md.	24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE Edward S. Kline		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05651

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First T. C.	Middle HOPKINS, III	4. DATE OF DEATH May 15 1960	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-12	9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Newburgh, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. C. Hopkins II		14. MOTHER'S MAIDEN NAME Florence Penney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT Mother		Address Mrs. J. T. C. Hopkins II, Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lupus erythematosus, disseminated</u> DUE TO <u>705.4</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Port Deposit	(County) Carroll	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>W. C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON		DATE SIGNED 5/16/60					
22a. BURIAL, CREMATION, REMOVAL <i>Private</i>		22b. DATE THEREOF 5-18-1960		22c. NAME OF CEMETERY OR CREMATORIAL Darlington		22d. LOCATION (City, town, or county) Darlington	
						(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR D. A. 18 '60		24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

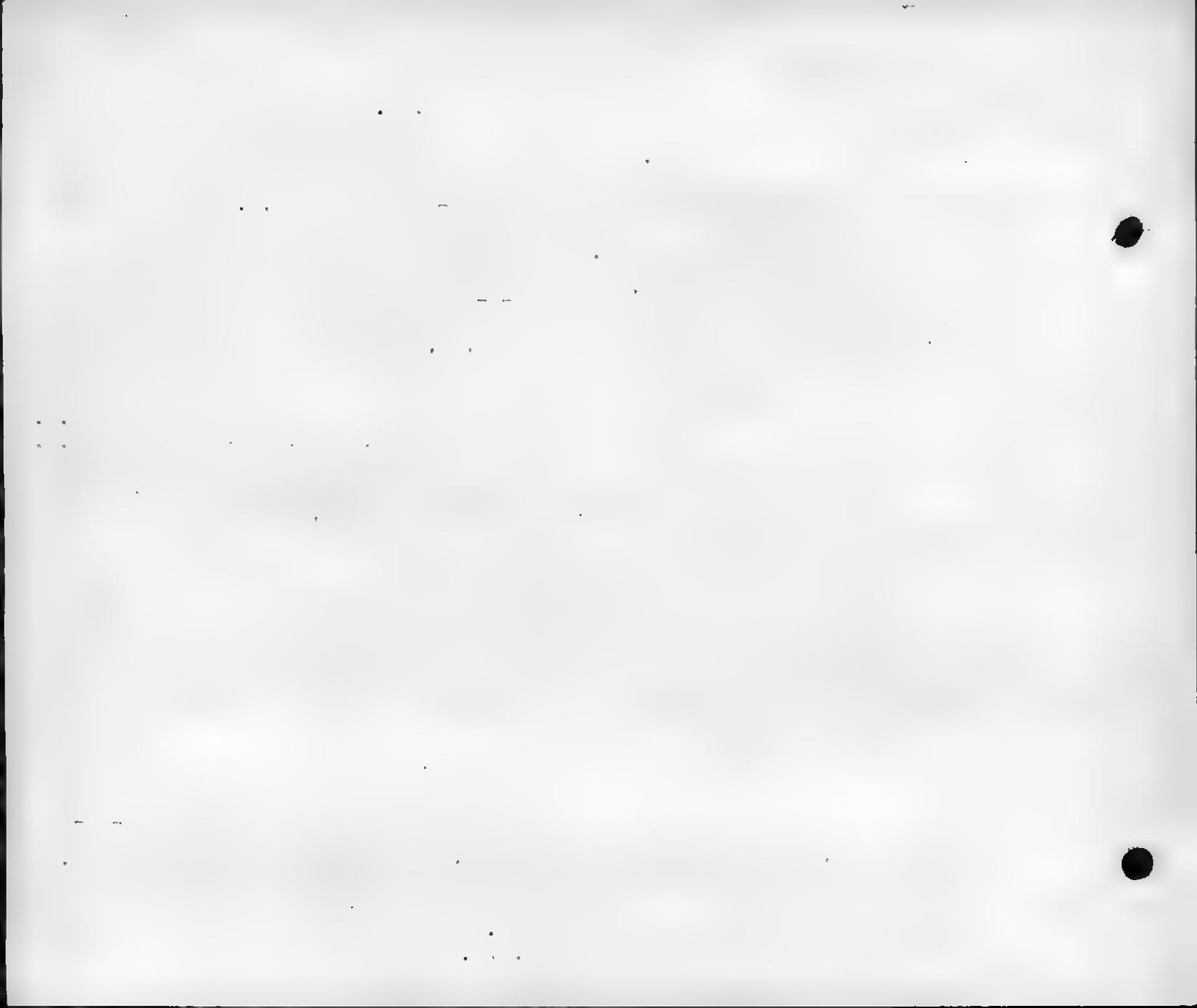
CERTIFICATE OF DEATH

Reg. Dist. No. **05652**

5670

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) First Virginia		4. DATE OF DEATH Month May Day 29 Year 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1, 1914	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY drugstore	
11. BIRTHPLACE (State or foreign country) Salem, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isner William Walton		14. MOTHER'S MAIDEN NAME Sally Bolen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 226-16-5595	
17. INFORMANT		Address Herman C. Hurlock, Sr. Singerly Rd. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Apr. 1, 1960 to 29 Apr. 1, 1960 , that I last saw the deceased alive on 29 Apr. 1, 1960 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1100 N. Hurlock M.D. North East, Md.	
ACTUAL SIGNATURE James H. Hurlock		DATE SIGNED 5/29/60	
PHYSICIAN'S NAME (Type) Klaus H. Hurlock M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/60	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS North East Methodist Cemetery		22d. LOCATION (City, town, or county) North East (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR DATE JUN 3 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hurlock	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

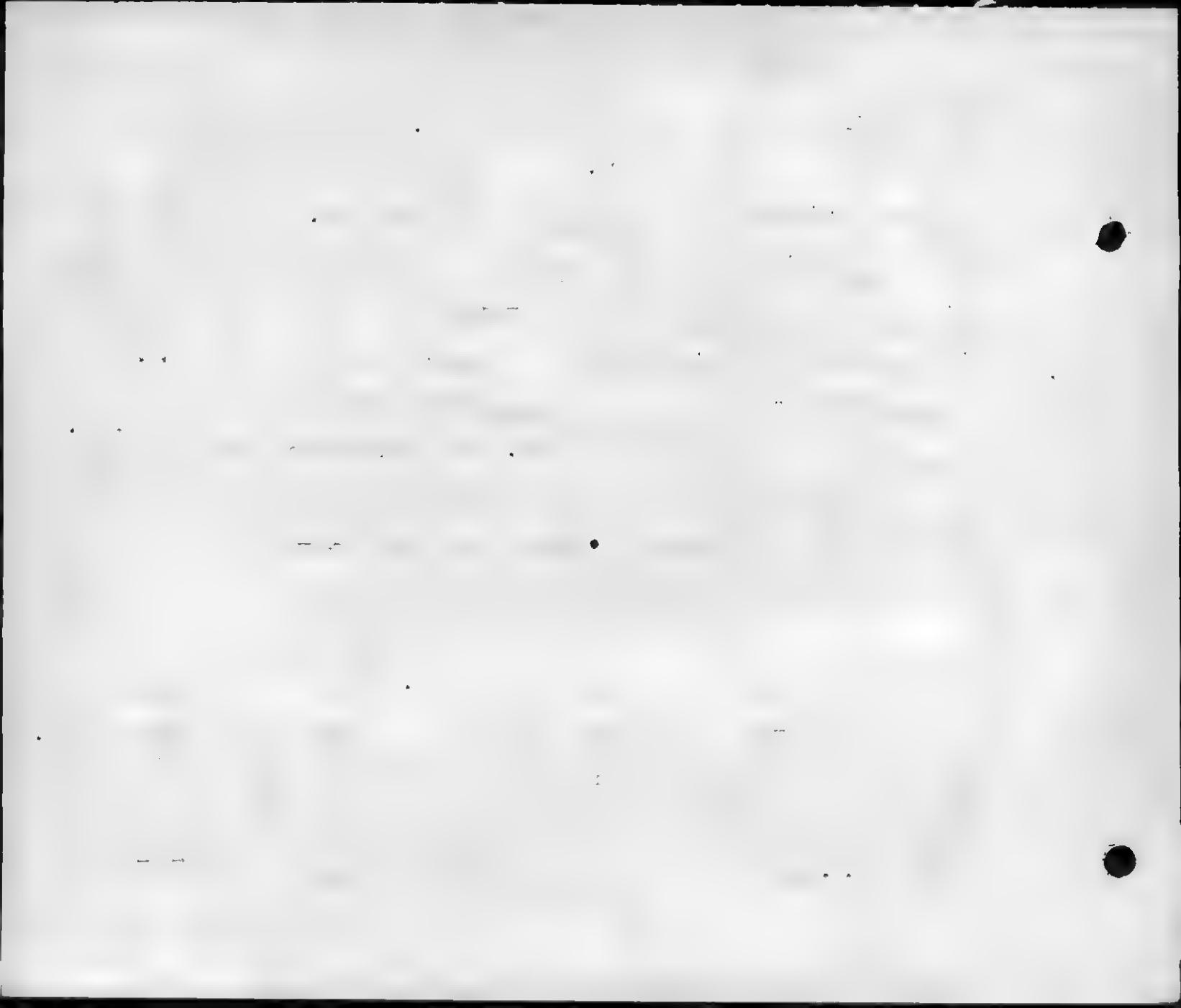
5671 Item 8 Film 203 5-4-61 at

Reg. Dist. No. 05654

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace	
c. LENGTH OF STAY IN 1b 2 hrs.		d. STREET ADDRESS 550 Fountain St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First Koendres	Middle Koendres
4. DATE OF DEATH 5 12 60	Month 5	Day 12	Year 60
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1916-10-07/9/687
9. AGE (in years last birthday) 72	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Worker Retired		10b. KIND OF BUSINESS OR INDUSTRY Street Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Koendres		14. MOTHER'S MAIDEN NAME Catharine Hollanhan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Harry Koendres, 1025 McDonnell Ave		Address Chester, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Coronary Occlusion Fracture of left femur pinned 4-16-60			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on the street of Havre De Grace	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4 16-60		20d. INJURY OCCURRED While or work <input type="checkbox"/> Not while or work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Havre De Grace	
(County) Harford		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> Actual Signature R.C. Dodson			
22a. BURIAL, CREMATION, Cremation REMOVAL (Specify) 5/16/60		22b. DATE THEREOF 5/16/60	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion		22d. LOCATION (City, town, or county) Hanover, Md.	
(State) Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paragon, Inc., Hanover, Md.		24a. REC'D BY REGISTRAR DATE MAY 19 '60	
ADDRESS Paragon, Inc., Hanover, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
X
M
5
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05655

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 9 mo. 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF First JAMES (Type or print)		d. STREET ADDRESS 401 N. Robinson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-6-88
10a. US JO. OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ignatius Kuchta (deceased)		14. MOTHER'S MAIDEN NAME Maria Schultz (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW I 212-20-0609	
17. INFORMANT Mary Koerner, sister, 425 N. Montford Ave.		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ICX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Prostatic obstruction (c)		INTERVAL BETWEEN ONSET AND DEATH 7-10 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>ICX</u> (this hospital) attended the deceased from <u>August 10, 1959</u> to <u>May 19, 1960</u> , ICX and that death occurred at <u>11:20 pm</u> from the causes and on the date stated above			
22a. SIGNATURE <u>J. L. Garey</u>		22b. DATE SIGNED 5-20-60	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-1960	
23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		23d. LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE LILLY & ZEILER, 1910 Eastern Ave. Balto. Md.		ADDRESS DATE MAY 23 '60	
		25a. REC'D BY REGISTRAR Charles J. Mann	
		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

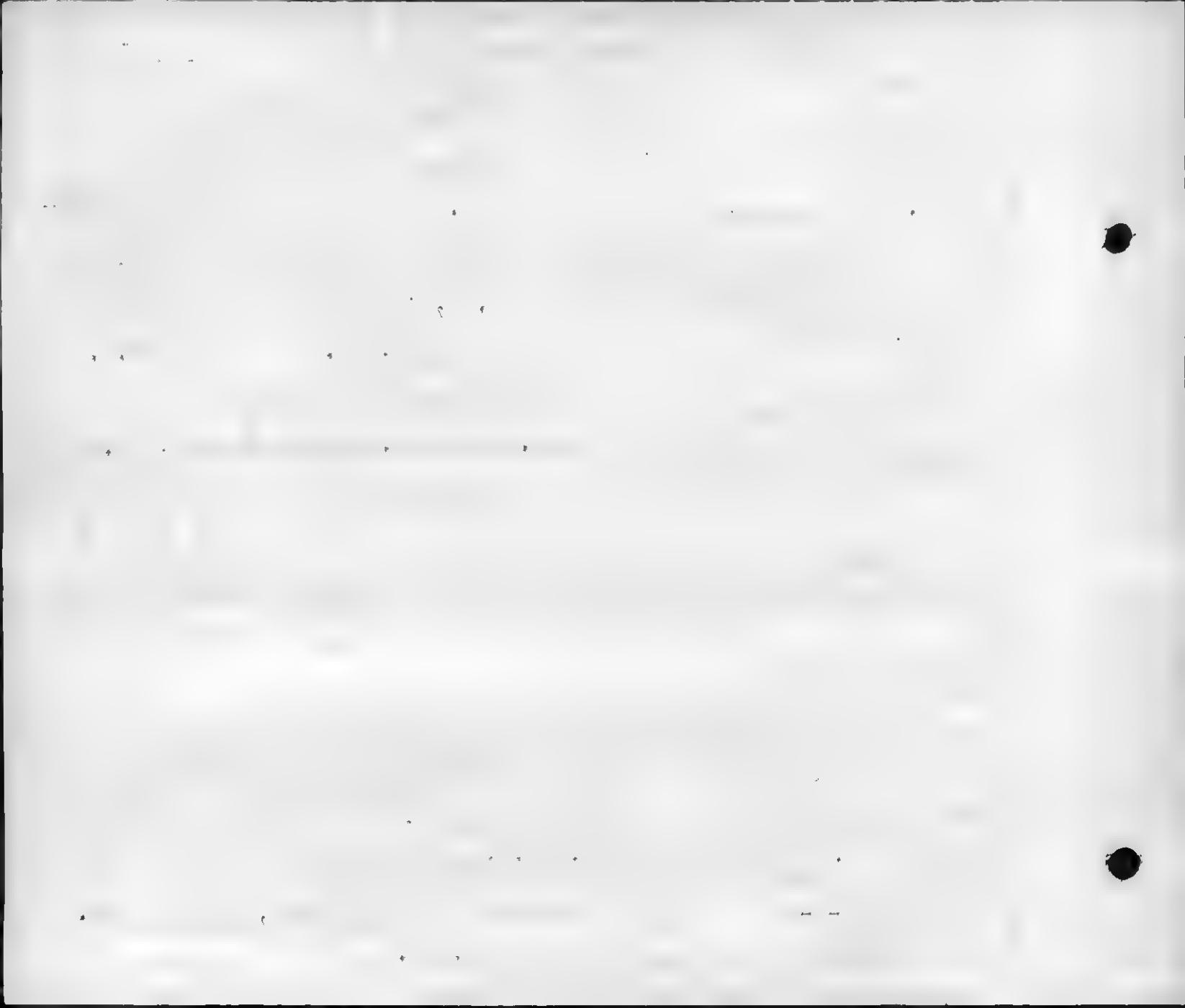
5672

CERTIFICATE OF DEATH

Reg. Dist. No.

15656

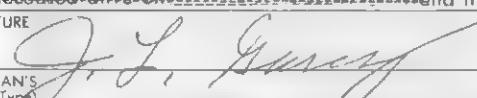
1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 232 W. Main Street,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 W. Main Street,						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARGARET		First ELLEN	Middle Mc DANIEL	Last May	DATE OF DEATH 29, 1960	Month May	Day 29	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elk Neck, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Barber				14. MOTHER'S MAIDEN NAME Sarah Ellen Hopkins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Sophie E. Steele, Elkton, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>Arteriosclerotic cardiovascular renal</i> disease				unknown		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 18, 1959 to May 29, 1960 , that I last saw the deceased alive on May 29, 1960 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 233 E. Main Street DATE SIGNED 5/30/60								
ACTUAL SIGNATURE <i>S. Ralph Andrews, Jr.</i>		PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-60		22c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery		22d. LOCATION (City, town, or county) Elkton, Md. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR John 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director.
 Page 3 should be detached for use as a burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5688 05657

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 5 mo. 3 days		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4630 Magnolia Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK		First R.		Middle MC KEAN		4. DATE OF DEATH May 15 1960		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-88		9. AGE (In years last birthday) 72 yrs.	
10a. JSUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John G. McKeon (deceased)		14. MOTHER'S MAIDEN NAME Sarah Coulter (deceased)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT not applicable		18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO liver and lymph nodes		Addres Baltimore, Md.	
								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis generalized moderately severe		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.									
21. I certify that (if this hospital) attended the deceased from December 12-59, to May 15, 1960, XXXXXX and that death occurred at 10:00 a.m. the causes and on the date stated above.									
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.		22d. ADDRESS Havre de Grace, Md.						22b. DATE SIGNED 5-17-60	
23a. BURIAL/CREMATION/REMOVAL (Specify) 6/18/60		23b. DATE THEREOF 6/18/60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.		25a. REC'D BY REGISTRAR MAY 20 60		25b. REGISTRAR'S SIGNATURE Cuthbert S. Keane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for filing.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7904

CERTIFICATE OF DEATH

09019

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION

Union Hospital, Elkton, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

b. COUNTY Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

Rural - Elkton

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF DECEASED

(Type or print)

First Middle Last

Oberer, Mrs. Emma C.

4. DATE OF DEATH

Month

Day

Year

5/ 19/ 1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

12/22/94

9. AGE (In years
last birthday)

65 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min

10a. USLA. OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Harry L. Kerkendell

14. MOTHER'S MAIDEN NAME

Dianna Ehrie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

in hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Feb, 1960, to May 19, 1960, that I last saw the deceased
alive on 19th, 1960, and that death occurred at M. from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Peter Stavrakis

M.D.

PHYSICIAN'S
NAME (Type)

Dr. Peter Stavrakis

Elkton, Maryland

22a. BURIAL CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/23/60

22c. NAME OF CEMETERY OR CREMATORIUM

EASTON Cemetery

22d. LOCATION (City, town, or county)

EASTON

(State)

Tenn.

23. FUNERAL DIRECTOR'S SIGNATURE

Ralph E. Hicks, Elkton, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

DATE AUG 18 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05658
 Reg. Dist. No.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. LENGTH OF STAY IN lb 20 minutes		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Training Hospital		e. STREET ADDRESS Charles St.		
3. NAME OF DECEASED (Type or print) Leona Belle		First Leona	Middle Belle	
4. DATE OF DEATH Year 5 8 19 60		Month	Day	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-1909	
9. AGE (in years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Jahn		14. MOTHER'S MAIDEN NAME Mary Ellen UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Ralph I. Pickard, Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 199 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? NO		INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PR.MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				DATE SIGNED
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5-8-60
22a. BURIAL, CREMATION, REMOVAL (if city) Burial		22b. DATE THEREOF 5-12-1960	22c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery	22d. LOCATION (City, town, or county) (State) Yeadon, Dela. Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson & Son, Perryville, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 12 '60	24b. REGISTRAR'S SIGNATURE <i>John E. Kline</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5690

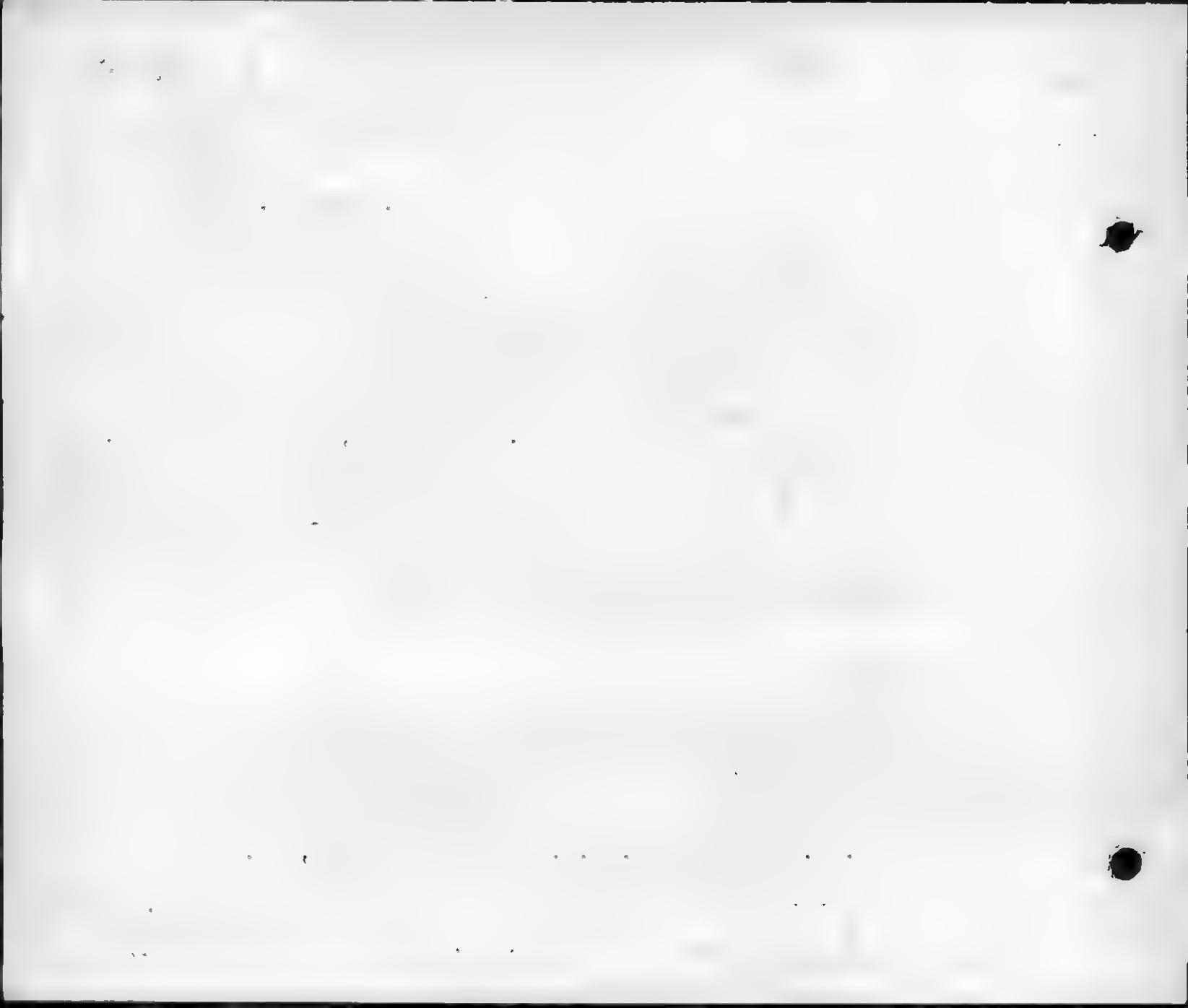
CERTIFICATE OF DEATH

05659

1 PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN lb 42 yrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 S. Main St.		d. STREET ADDRESS 50 S. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Viola	Middle Creamer	Last Roe	4. DATE OF DEATH	Month May	Day 5	Year 19 60
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1885		9 AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry Creamer		14. MOTHER'S MAIDEN NAME Nettie Mitchell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT R. James Roe, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Fracture. Fracture of the left forearm due to a fall from a chair.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO Fracture. Fracture of the left forearm due to a fall from a chair.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1960</u> to <u>Sept 5, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 5, 1960</u> and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. H. Richards Jr. M.D.</u>		M.D.	ATTENDING PHYS	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>5/6/60</u>	
22c. PHYSICIAN'S NAME (Type) G. H. Richards Jr. M.D.		22d. ADDRESS Port Deposit, Md.					
23a. BURIAL, CREMATION, BURNING (Specify) Burial	23b. DATE THEREOF 5-7-1960	23c. NAME OF CEMETERY OR CREMATORIUM Hopewell Cemetery			23d. LOCATION (City, town, or county) Port Deposit, Md. Rural		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leva Patterson, Jr.</u>		ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR Date MAY 9 '60		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5691

CERTIFICATE OF DEATH

05660

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elm St.		d. STREET ADDRESS Elm St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Addie	Middle Helen	Last Sentman	4. DATE OF DEATH May 30 1960	Month May	Day 30	Year 1960
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 26, 1868	9. AGE (In years lost birthday) 91 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Peter Gillespie	14. MOTHER'S MAIDEN NAME Amanda Harris	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or No)	16. SOCIAL SECURITY NO None	17. INFORMANT Miss Irene Sentman, Perryville, Md.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 124 X Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Sclerosis (c) DUE TO Arterio Sclerosis -	INTERVAL BETWEEN ONSET AND DEATH 5 yrs -
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19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
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20c. TIME OF INJURY Month, Day, Year Hour o m p. m 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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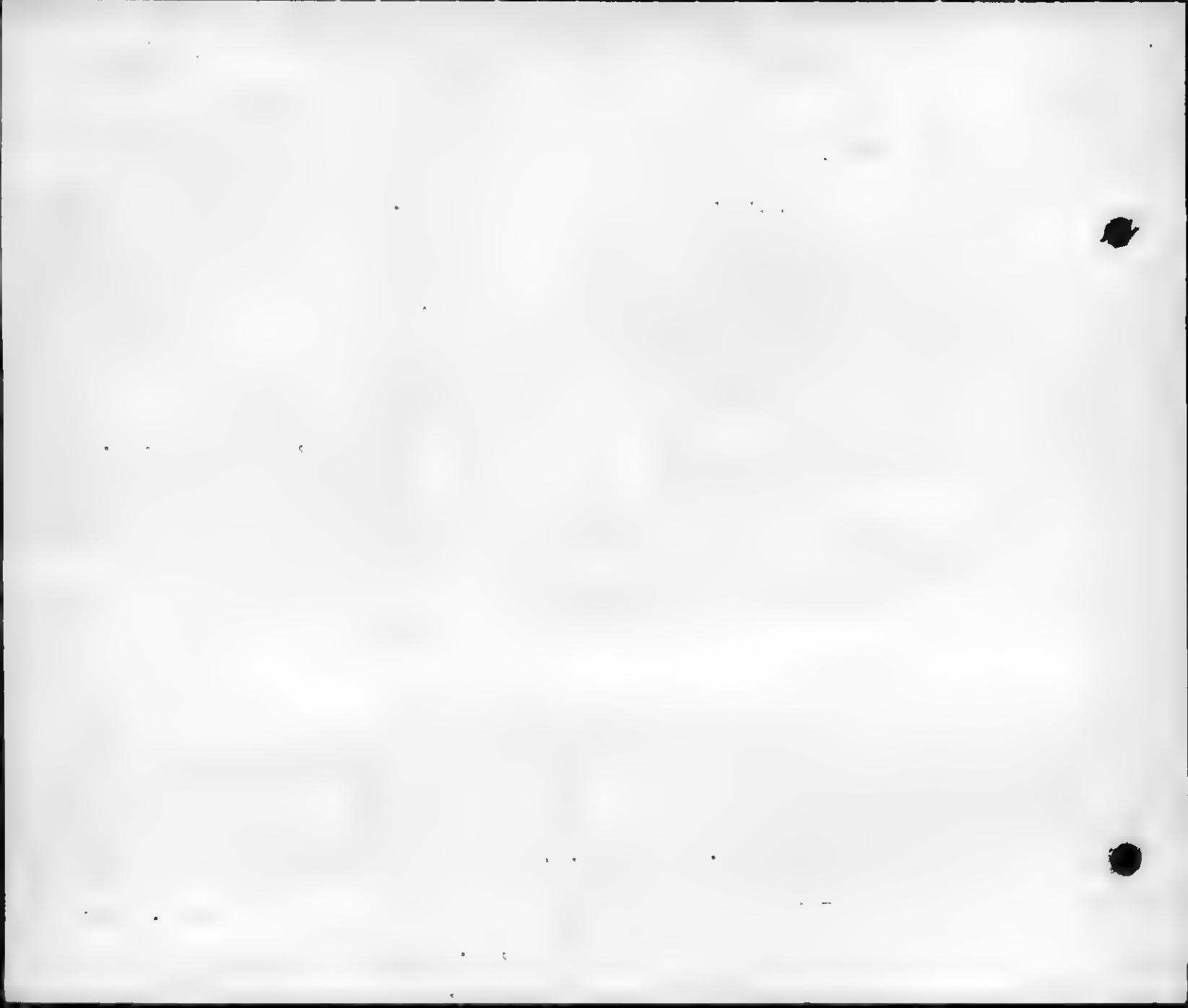
21. I certify that (I) (this hospital) attended the deceased from July 26 to July 29 1960, that (I) (we) last saw the deceased alive on July 29 1960, and that death occurred at 530 pm from the causes and on the date stated above
--

22a. SIGNATURE Clarence I. Benson, M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED July 31-60
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22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.	22d. ADDRESS Patapsco, Md.
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23a. BURIAL OR CREMATION REMAINS Cremation	23b. DATE THEREOF 6-2-1960	23c. NAME OF CEMETERY OR CREMATORIAL Hopewell	23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
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24. FUNERAL DIRECTOR'S SIGNATURE Leesa Patterson & Son	ADDRESS Perryville, Md.	25a. REC'D BY REGISTRAR DATE JUN 2 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kline
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5692

CERTIFICATE OF DEATH

05661

DO NOT HOSPITALIZE **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. **Page 4** may be signed by the hospital or attending physician.

DO NOT FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **Pages 1 and 2** should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 85662

5673

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mass. b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westfield State Sanitarium		f. STREET ADDRESS Westfield, Massachusetts		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond		First J.	Middle Soyeur	Last Soyeur	4. DATE OF DEATH MAY Month March 28 Day 1960 Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4/27/04	9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Great Barrington, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Soyeur		14. MOTHER'S MAIDEN NAME Caroline Adams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 027-16-8116		17. INFORMANT Ernest J. Soyeur, Great Barrington, Mass.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), <u>sliding the underlying cause last.</u> (b) DUE TO (c)							
Cerebral laceration sub arachnoid and subdural hemorrhage, fracture right superior ramus pubic bone with displacement and hemorrhage, rt inguinal hernia							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Car went off roadway (Deceased was passenger in car)					
20c. TIME OF INJURY Hour 2:20 p. m.		Month, Day, Year 5/26 1960	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off a bldg., etc.) US 40	20f. (City or town) nr. Elkton	(County) Cecil	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) R. C. Dodson, M.D.		DATE SIGNED 5/28/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-60		22c. NAME OF CEMETERY OR CREMATORIAL Elmwood Cemetery		22d. LOCATION (City, town, or county) Great Barrington, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS <i>Elkton, Md.</i>		24a. REC'D. BY REGISTRAR John W. '60		24b. REGISTRAR'S SIGNATURE <i>John W. '60</i>	

1. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a 1/2 certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

2. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3. To the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

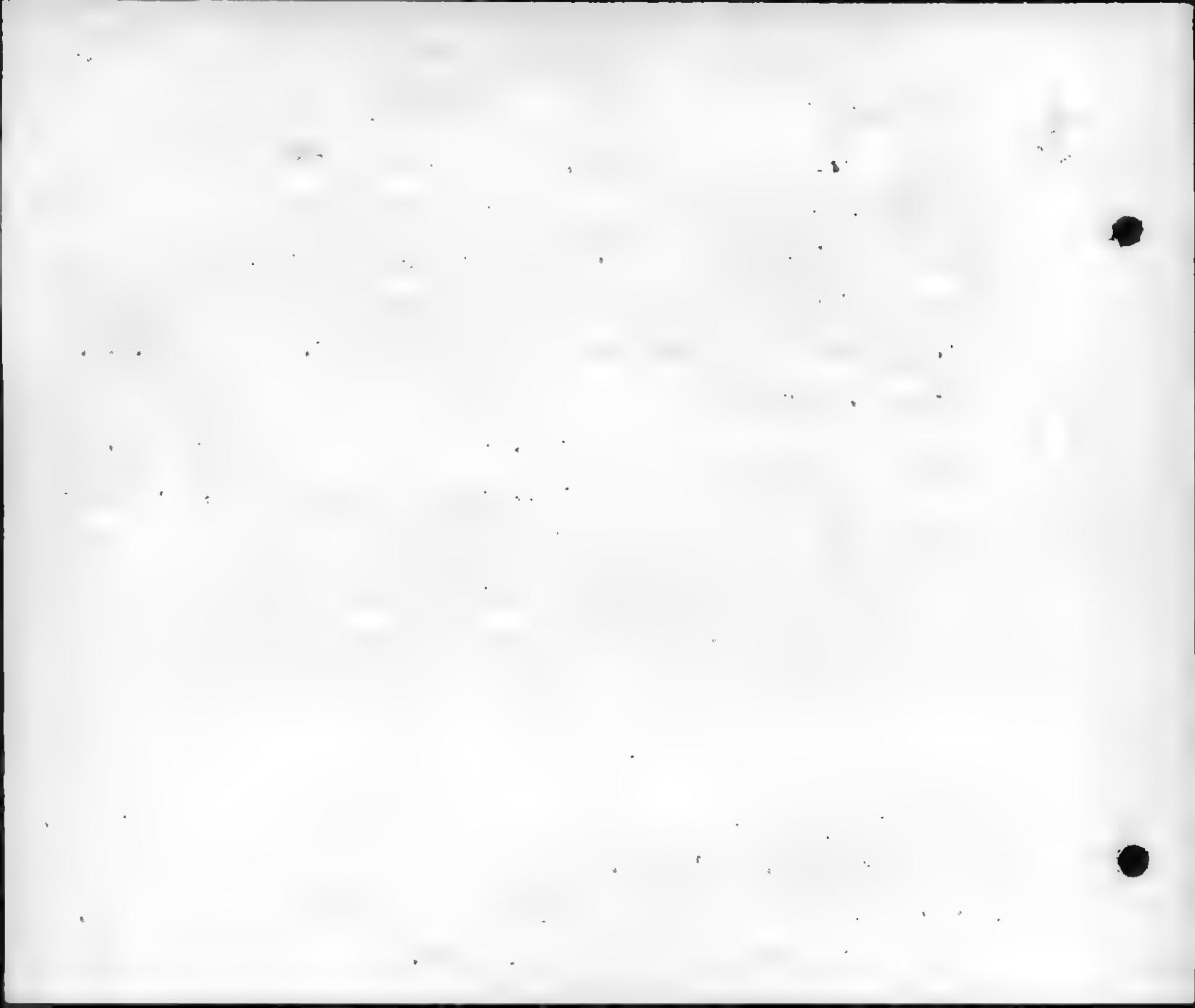
5674

CERTIFICATE OF DEATH

05663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 26 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 Kentmere Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MILFORD	Middle H.	Last Sprecher
4. DATE OF DEATH	Month MAY	Day 18	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1905
9. AGE (In years last birthday) 54 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor	10b. KIND OF BUSINESS OR INDUSTRY Medicine	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George H. Sprecher	
14. MOTHER'S MAIDEN NAME Effie Harsh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margot Sprecher, Elkton, Md.	18. ADDRESS
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) Coronary Occlusion = Infarction massive instant Due to ArterioSclerotic Coronary Disease (c) Recent Myocardial Infarction 2 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1953 Massive Pulmonary Tuberculosis			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) Elkton, Md.		(County)	(State)
21. I certify that I attended the deceased from 26 March, 1960 , to 18 May, 1960 , that I last saw the deceased alive on 18 May, 1960 , and that death occurred at Elkton, Md. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Elkton, Md.			
ACTUAL SIGNATURE George J. Kreis, Jr.		DATE SIGNED 5/20/60	
PHYSICIAN'S NAME (Type) GEORGE J. KREIS, JR.			
22a. BURIAL, CREMATION REMOVAL. (Specify) Burial		22b. DATE THEREOF May 21, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Elkton Cemetery		22d. LOCATION (City, town, or county) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR Elkton, Md. MAY 25 '60	
ADDRESS Donald A. Dex		24b. REGISTRAR'S SIGNATURE Orlina S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15664

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, P.D.		c. LENGTH OF STAY IN 1b 56 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, P.D. #3	

3. NAME OF DECEASED (Type or print)	First Ernest	Middle F.	Last Stewart	4. DATE OF DEATH 5	Month 2	Day 19	Year 60
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-1920	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Maker	10b. KIND OF BUSINESS OR INDUSTRY Elkton Paper Co.	11. BIRTHPLACE (State or foreign country) Maryland Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Harvey E. Stewart	14. MOTHER'S MAIDEN NAME Sarah Ann Dick
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 214-07-0378	17. INFORMANT Mrs Edna Judd Hollingsworth M nor Elkton, Md
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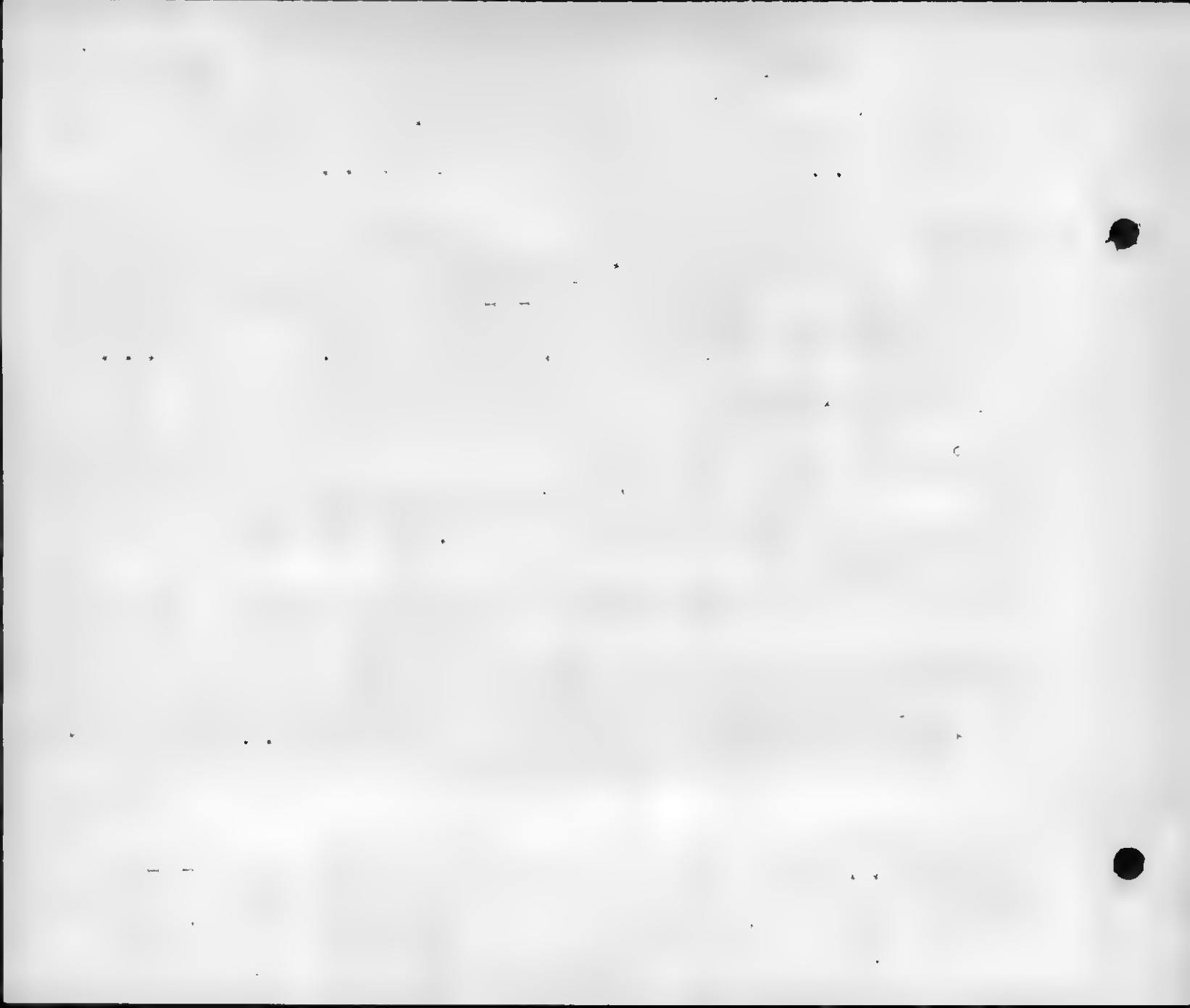
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet Hole right side of head above right ear (c) exit corner left eye at nose. Lacerated left side of (d) throat		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS SHOT or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 32caliber Revolver	
20c. TIME OF INJURY Month, Day, Year Hour 12.50 p.m. 5 24 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton, P.D. #3 Cecil Md.

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <i>R.C. Dodson</i>	DATE SIGNED 5-25-60

EXAMINER'S NAME (Type) R.C. Dodson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 28, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Immaculate Conception	22d. LOCATION (City, town, or county) Elkton Cecil Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>	ADDRESS North East, Maryland	24e. REC'D BY REGISTRAR Arthur S. Krause	24f. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05665

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville.		c. LENGTH OF STAY IN lb 2 Days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) V.A.H. Perry Point, Md		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit,				
3. NAME OF -DECEASED (Type or print) Leroy		d. STREET ADDRESS 224 N. Main Street				
4. DATE OF DEATH May 11, 1960		Month	Day			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-99			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Boiler)		10b. KIND OF BUSINESS OR INDUSTRY Hospital				
11. BIRTHPLACE (State or foreign country) Gravelly Hill, Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William H. Taylor		14. MOTHER'S MAIDEN NAME Georgianna Warfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) NO		16. SOCIAL SECURITY NO. Hannah Taylor (W) Pt. Deposit, Md.				
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractures, Multiple, of the left calvarium, temporal and frontal fossa, with loss of brain substance DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subdural hemorrhage, right. DUE TO (c) Multiple contusions and abrasions of the head and lacerations of left ear				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ladder 18 feet hitting floor				
20c. TIME OF INJURY Hour 3:30	Month, Day, Year 5/9/60	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) V.A. Hospital	20f. (City or town) Perry Point, Cecil	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE W. E. Rodden		DATE SIGNED				
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 5/15/60		22c. NAME OF CEMETERY OR CREMATORIAL Forest Haven Cemetery		22d. LOCATION (City, town, or county) W. E. Rodden
23. FUNERAL DIRECTOR'S SIGNATURE Forest Haven Cemetery		ADDRESS		24a. REC'D BY REGISTRAR May 16 '60		24b. REGISTRAR'S SIGNATURE John S. Kress

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5675

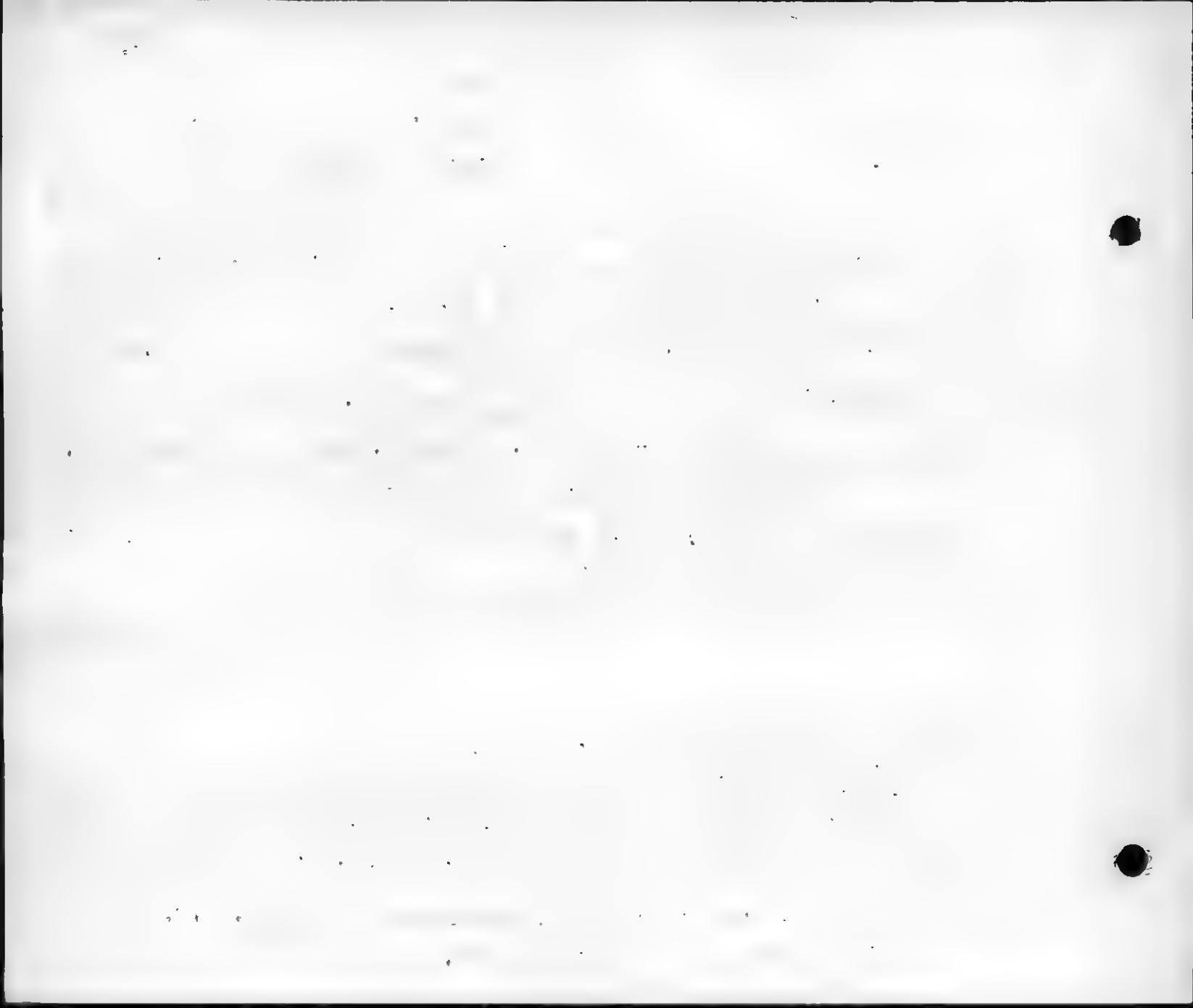
CERTIFICATE OF DEATH

05566

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton.		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN	First HENRY	Middle TAYLOR	4. DATE OF DEATH Month May 31, 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1927
9. AGE (In years last birthday) 32 yrs.	10. KIND OF BUSINESS OR INDUSTRY Gen. Motors	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Taylor	14. MOTHER'S MAIDEN NAME Goldia E. Eller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown	16. SOCIAL SECURITY NO. 230-28-7121	INFORMANT Mrs. Evelyn S. Taylor	Address Elkton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction (Stomach)		INTERVAL BETWEEN ONSET AND DEATH one month	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X		DUE TO (b) Carcinoma of Stomach	
DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 31 , 1960, to May 31 , 1960, that I last saw the deceased alive on May 31 , 1960, and that death occurred at 501 N. Main St. from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Henry V. Davis</i>	M.D.		ADDRESS (Street, city or town, state) Chesapeake, Md.
PHYSICIAN'S NAME (Type) HENRY V. DAVIS	DATE SIGNED 5/31/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 4, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mountain Union Cemetery	22d. LOCATION (City, town, or county) Ashe Co., N.C.
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME	ADDRESS Donald R. DeElkton, Md.	24a. REC'D BY REGISTRAR JUN 2 '60	24b. REGISTRAR'S SIGNATURE Charles S. Klaus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

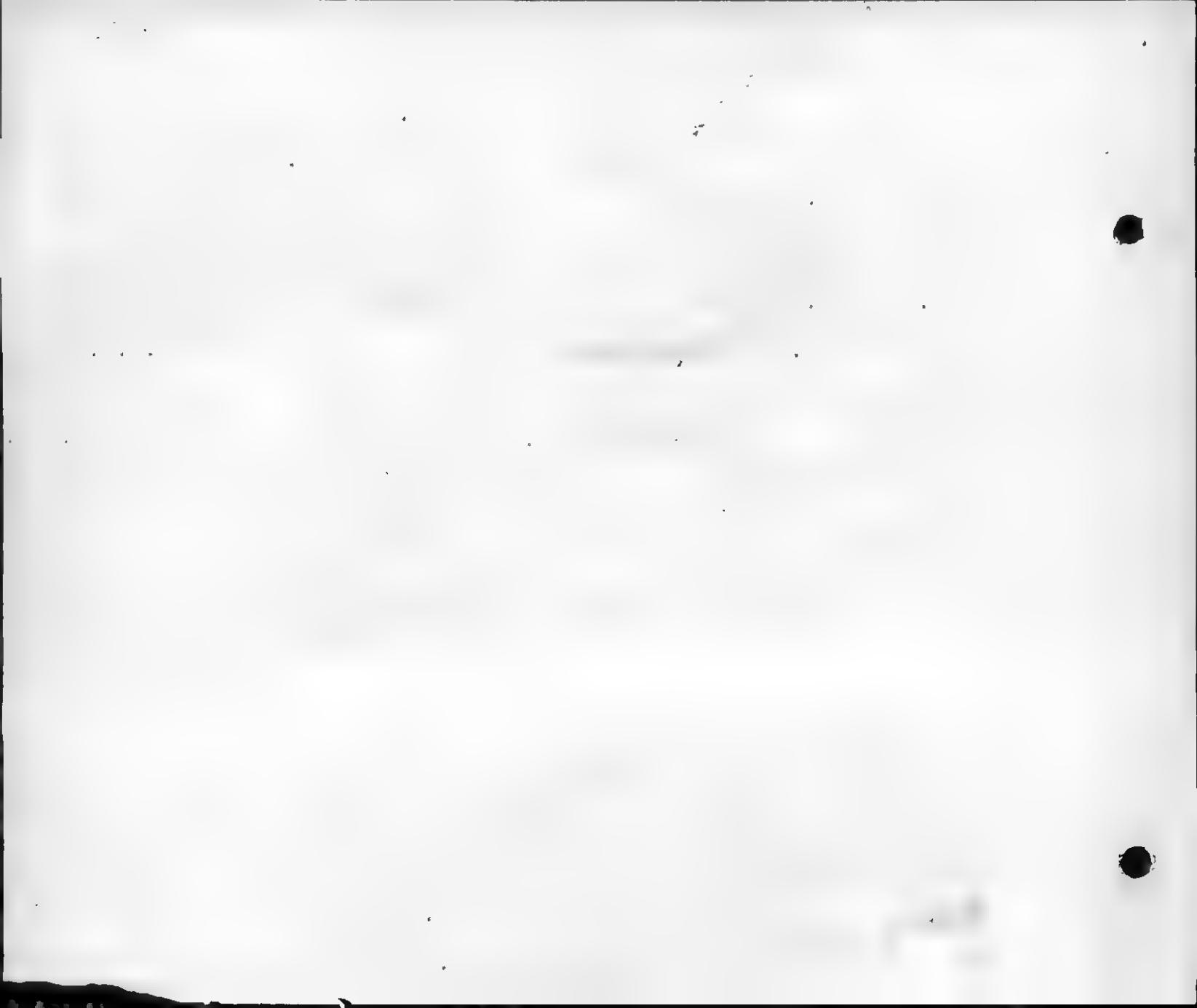
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5677

CERTIFICATE OF DEATH

05667
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RISING SUN, MD. RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) UNION HOSP.		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RANDEL		First ALBERT	Middle TRIMBEL
4. DATE OF DEATH 5 / 10 / 1960	Last TRIMBEL	Month 5	Day 10
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/7/1900
9. AGE (In years last birthday) 59 yrs	10. KIND OF BUSINESS OR INDUSTRY Building Construction	11. BIRTHPLACE (State or foreign country) CECIL CO., MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR RET.		14. MOTHER'S MAIDEN NAME ELLA BARROW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO 214-18-3574	
17. INFORMANT MRS. MARGARET HOLLOWELL PORT DEPOSIT, MD.		Address	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 330 X DUE TO Spontaneous subarachnoid hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Hypertensive vascular disease, never (c)		INTERVAL BETWEEN ONSET AND DEATH 15d.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 27, 1960, to May 10, 1960, that I last saw the deceased alive on May 10, 1960, and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE T. Ward Johnson PHYSICIAN'S NAME (Type) T. Ward Johnson 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/13/1960 22c. NAME OF CEMETERY OR CREMATORIUM PLEASANT GROVE CEM. 22d. LOCATION (City, town, or county) PEACH BOTTOM (State) PA.			
23. FUNERAL DIRECTOR'S SIGNATURE Tommy E. Mueller		24a. ADDRESS Rising Sun, Md.	24b. REC'D BY REGISTRAR DATE MAY 16 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05668

5678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARION	Middle E.	Last ULMER
4. DATE OF DEATH	Month 5	Day 8	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1937
9. AGE (In years last birthday) 22 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Davis	14. MOTHER'S MAIDEN NAME Florence Colver	Address Francis L. Ulmer Elkton, Md. RD# 4	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	INFORMANT
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of CERVIX		INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/22 , 19 60 , to 5/8 , 19 60 , that I last saw the deceased alive on 5/8 , 19 60 , and that death occurred at 9:50 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) John A. Fischer M.D. 162 W MAIN ST. Elkton, Md.			
ACTUAL SIGNATURE John A. Fischer		DATE SIGNED 5/8/60	
PHYSICIAN'S NAME (Type) John A. Fischer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 11, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Newark Cem.	22d. LOCATION (City, town, or county) (State) Newark, Del.
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones	ADDRESS Newark, Del.	24a. REC'D BY REGISTRAR DATE MAY 23 '60	24b. REGISTRAR'S SIGNATURE Charles S. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05669

5694

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
3. NAME OF DECEASED (Type or print) JOHN		First A.	Middle WILFONG
4. DATE OF DEATH May 5 1960		Month May	Day 5
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4-7-19		9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Truck driver	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John C. Wilfong	
14. MOTHER'S MAIDEN NAME Elizabeth Simons		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 223-14-9186		17. INFORMANT Mrs. Nada Wilfong, Wife, 5625 Columbia Pike Falls Church, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 954 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Biopsy of Larynx under general anaesthesia		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (b) (this hospital) attended the deceased from April 28 1960 to May 5 1960 , XXXXXX XXXXXX and that death occurred at 2:15 p.m. the causes and on the date stated above.		22b. DATE 5-5-60	
22c. SIGNATURE J. L. Garey		22d. ADDRESS J. L. GAREY, Clinical Pathologist, V.A. Hospital, Perry Point, Md.	22b. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 5/6/1960	23c. NAME OF CEMETERY OR CREMATORIAL Marmet
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	25a. REC'D BY REGISTRAR DATE MAY 10 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kline

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5695

05670
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 8 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air 1232.2				
3. NAME OF DECEASED (Type or print) RICHARD		First G.	Middle WYSONG			
4. DATE OF DEATH May 10 1960	Month Day Year	5. SEX Male				
6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/12/30	9. AGE (In years last birthday) 29 yr.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Student	10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis Wysong		14. MOTHER'S MAIDEN NAME Mary Wright				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 184-22-2815 Unknown	17. INFORMANT Mrs. Mary Wysong, Mother	Address 636 Rock Spring Rd. Bel Air, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 900.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down step of building and hit his head on stone step				
20c. TIME OF INJURY Hour 2:00 p. m.	Month, Day, Year 5/5 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building 24	20f. (City or town) VA Hospital, Perry Point, Md.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> R. C. Dodson						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/10/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 12, 1960	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rock Spring	22d. LOCATION (City, town, or county) Forest Hill	(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE	Joseph T. Foster		24a. REC'D BY REGISTRAR DATE MAY 12 '60	24b. REGISTRAR'S SIGNATURE Charles J. Francis		
Joseph T. Foster Funeral Home, Bel Air, Md.						

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